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Articles

# Views on Mental Health assistance in Primary Care at small cities: emergence of innovative practices

Olhares sobre a assistência em Saúde Mental na Atenção Primária à Saúde em municípios de pequeno porte: emergência de práticas inovadoras (resumo: p. 17)

Miradas sobre la asistencia en Salud Mental en la Atención Primaria de la Salud en municipios de pequeño porte: emergencia de prácticas innovadoras (resumen: p. 17)

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Mental health actions in primary care are a challenge within the scope of the Brazilian Psychiatric Reform. We aimed to understand the primary care practices provided for people with mental illness in small cities. This qualitative study used ethnomethodology and involved primary care managers and professionals from cities located in Vale do Jequitinhonha. The results enabled us to systematize primary care actions: to unveil the world of intramural mental disorders through home visits and presence at schools; to move between different universes, from traditional formats to mental health problems arising from the social media; to expand the approach to and support for mental health patients; and to perceive the transfer of stigmas operating in the mental health network. We conclude that primary care, which has the provision of humanized care as one of its principles, is part of the project of the Brazilian Psychiatric Reform and deepens it.

**Keywords:** Mental health. Primary care. Family health strategy. Brazilian psychiatric reform.

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## Introduction

Issues related to mental health (MH) have become a worldwide health problem, totaling approximately 12% of the global burden of disease. Common mental disorders alone affect one third of the population, being one of the most prevalent psychological morbidities in the world[1]. In Brazil, it is estimated that this prevalence ranges between 29.6% and 47.4%[2,3].

In view of these data, the question is: How can the health services deal with this prevalence and build a new reality? The World Health Organization (WHO) mentions reasons why MH care should be integrated into Primary Health Care (PHC): the burden of mental disorders is high; mental and physical health problems are interconnected; the treatment deficit concerning mental disorders is huge. The document also emphasizes that primary care for MH improves access to care, promotes respect for human rights, has a good cost-benefit ratio and generates better health outcomes[4]. Therefore, professionals in PHC teams should absorb this demand, conducting MH promotion actions and preventing and treating mental illness, in an individual and collective way.

In Brazil, the Movement of Mental Health Workers, whose purpose is the reformulation of psychiatric care, is an abundant source of historical and social possibilities, promoting activities and producing legal texts that legitimize the entire political, ethical, institutional and scientific process called the Brazilian Psychiatric Reform. The change promoted by the Brazilian Psychiatric Reform shifts the focus from hospital care, centered on the biomedical model, to psychosocial care, provided for users in the community[5].

Thus, the challenge is to inhabit the circuits of exchanges in society's territories, instead of creating parallel and protected life circuits for users. This takes the challenge of including MH actions in PHC beyond the Brazilian National Health System (SUS): to achieve this, society needs to open itself to its own diversity[6].

Studies carried out in Norway[7] and Brazil[8] have shown that, despite several innovative initiatives in care provided for people with mental illness in PHC, aspects like problems related to the organization of the working process, insufficient professional education, the precarious structuring of the services network, and the incipient infrastructure and human resources, hinder the inclusion of MH actions in PHC. These weaknesses are barriers to care provision in PHC, as they promote the reproduction of the asylum and biomedical model, lack of focus on users and their families, duplicity of care models, unnecessary referrals, and absence of co-accountability.

However, studies have shown that innovative practices have been experienced in MH care within the Brazilian PHC. A broad review has shown that, in the city of Salvador (Northeastern Brazil), home hospitalization is a possible reality. In the city of Ribeirão Preto (Southeastern Brazil), home visits minimize the incidence of psychiatric readmissions through follow-up of discharged patients, guidance for families, and efforts to avoid the medicalization of mental suffering. In the city of Cuiabá (Central-Western Brazil), the therapeutic group is a way of integrating MH into PHC[9]. In São Paulo (Southeastern Brazil), home visits and qualified listening facilitate the process of identifying and meeting the needs of users with mental illness[10].

Other national studies, developed in the states of São Paulo, Rio Grande do Norte, Paraíba, and also in the south region of Brazil, have shown the importance of group practices in PHC, like Community Therapy and MH Groups and Workshops. The studies highlight that people sharing experienced situations is a powerful possibility, indicating that the strengthening of the bonds of trust between users and professionals can be an important tool for MH promotion and preservation[9].

Furthermore, a study carried out in the city of São Paulo has found that the strategy of holding team meetings with case discussion, effective support to workers' difficulties and development of the Individual Therapeutic Project is used as a way of qualifying teams to tackle the difficulties that arise from including MH practices in PHC[11].

In the international scenario, experiences of MH actions in primary care are reported by studies developed in England, Australia, Finland and the United States of America. The results of these studies provide some evidences: joint discussion of cases as the main form of articulation between the services; association between improved assistances and the possibility of sharing knowledge[12]; significant reduction in referrals when the general practitioner is the reference professional[13]; significant improvement in the capacity for meeting users' needs, with shared psychotherapy sessions[14]; continuity of treatment in the primary services that have partnerships with the secondary sector, with high adherence rates[15].

These MH practices, in the context of the Brazilian and international PHC, contribute to improve care provided for people with mental illness, as the included actions innovate and qualify PHC.

In light of these possibilities, this study aimed to understand the practices that are being performed in the PHC of small cities for people with mental disorders. The study was guided by the following question: What practices are performed in the daily routine of PHC in small cities to provide care for people with mental disorders?

## Method

Qualitative study based on ethnomethodology, understood as the empirical study of common sense practices, procedures, methods and knowledge that social actors use on a daily basis to understand and, at the same time, produce the social environments in which they participate[16]. We chose ethnomethodology due to our aim of investigating the MH practices of Family Health Strategy teams in small cities.

In this methodological approach, the members of a group use natural language in the daily settings that compose the social world, which implies that practical activities and social interactions occur within a common horizon of understanding. To apprehend these dimensions in the reality of MH, we used individual interviews with PHC managers and coordinators and discussion groups with professionals working in PHC teams, based on a script with the guiding request: Tell us how MH actions are organized and developed in your unit.

The study was conducted from July to November 2019 in cities located in Vale do Jequitinhonha, State of Minas Gerais (Southeastern Brazil). The cities were numbered from 01 to 05 according to the chronological order of the interviews and discussion groups. The cities have the following characteristics, among others:

**Frame 1.** Characteristics of the study's cities

| Cities | Inhabitants | Healthcare Network Devices | | | |
|---|---|---|---|---|---|
| | | ESF* | NASF-AB** | CAPS*** | CRISIS BED**** |
| 01 | 11.818 | 05 | 01 | 00 | 00 |
| 02 | 10.256 | 05 | 01 | 01 | 01 |
| 03 | 24.131 | 08 | 02 | 02 | 02 |
| 04 | 36.712 | 13 | 02 | 02 | 04 |
| 05 | 11.872 | 03 | 01 | 01 | 01 |
| Total | 84.968 | 34 | 07 | 06 | 08 |

Sources: data from IBGE 2017 and the researcher's archives. *Family Health Strategy ** Extended Family Health and Primary Care Center *** Psychosocial Care Center ****Emergency bed in a general hospital.

All the cities that accepted the invitation to participate in the study were included. The participants signed a consent document. Theoretical saturation of data was used to delimit the sample, that is, we stopped sampling data when no new element was found and the objective of the research was fulfilled[17].

We conducted 11 interviews with PHC managers and coordinators and 10 discussion groups with PHC teams, totaling 85 participants. The number of participants in the discussion groups varied between 6 and 12. The average duration of the discussion groups was one hour. The average duration of the interviews was approximately 30 minutes.

The individual interviews and the group discussions were fully transcribed. All the language was preserved, including the colloquial tone. Then, we listened to the audios repeatedly and read the transcribed discourses in detail.

Data analysis was based on the presupposition of ethnomethodology. Instead of formulating the hypothesis that the actors follow the rules, ethnomethodology is interested in studying the methods employed to update the rules, which makes them observable and descriptive[15]. The members' practical activities in their concrete activities reveal the rules and procedures. Thus, the focus of this study was to investigate the implementation of MH actions in PHC. There is a conceptual framework based on the Brazilian Health Reform that explains the role of PHC in health actions. We aimed to investigate how PHC is related in practice to this process. To achieve this, the analysis of the collected material was organized around three important concepts of ethnomethodology: social actor, social order and social action[17].

Concerning the social actor, the point-of-departure was the conception that actors have a set of resources and procedures that enable them to act in their social world. They neither discuss nor reflect on the categorizations and methods they use to face different situations; rather, they employ them tacitly and routinely[18].

In this aspect, we tried to identify how different workers in PHC teams interact, in their daily routine, with the universe of actions produced in the sphere of MH. We aimed to identify what knowledge and procedures they use as resources in the daily routine of the production of MH actions that enable them to enhance their actions.

As for social order, in ethnomethodology it is perceived in the sphere of practice of the members who participate in society, rather than a set of facts or institutions imposed on the actors and restraining them. Therefore, social reality is understood as a framework of "contingent achievements of common organizational practices"[19].

Ethnomethodology works with two fundamental concepts to approach social reality as a situated production determined by the various methods (ethno) (resources, practices, procedures, knowledge) that people employ to produce the social order that they inhabit[16].

The first concept is indexicality, which refers to the expressions employed by social actors in interactive processes, which have meaning in the moment of the interaction and in the local context where it is produced. Thus, ethnomethodology studies language, giving special attention to new meanings attributed to certain words over the years. In addition, indexicality understands that the new meanings attributed to words are due to the interaction that the individuals establish[18].

The second concept is reflexivity, which presupposes that actions developed by individuals are provoked by the reflection they make on the actions performed by others and by the individuals themselves. These reflections are made in an instinctive way, that is, the person reflects without deliberate perception or will - it is spontaneous. This reflexivity makes individuals rely on it to generate their own acts[16].

We focused on the several modalities of action and practical reasoning that the participants mobilize to recognize, include, produce and sustain their MH actions. In addition, we identified the expressions and contexts in which new meanings have been attributed to MH actions in the reality of PHC.

As for social action, ethnomethodology replaces the investigation of the reasons for an action with the investigation of how a specific field of actions that contains its own intelligibility emerges[16]. It also focuses on how the field is organized and how different subjects articulate with one another.

Therefore, we investigated how the MH conceptions present in the set of ideas of the Brazilian Health Reform are configured in practice, and how they are expressed in the reality of PHC in the analyzed teams. That is, how are these spaces organized in the daily production of healthcare and in MH? Could it be that new norms are emerging? How are the norms expressed in the daily routine?

The collected material was analyzed based on those outlines. This study complies with Resolution no. 466 of December 12, 2012, of the National Health Council, and was approved by the Research Ethics Committee of the Federal University of Minas Gerais (UFMG), opinion No. 28804.

## Results

Various aspects emerged from the MH practices that are being performed by PHC in the analyzed cities, which reflects their complexity. In what follows, we systematized these aspects, categorizing and describing them based on the discourse of the PHC teams and coordinators.

### Unveiling the world of intramural mental disorders: the deep meaning of the home visit and of the presence in schools

In the identification of MH problems in the PHC of the analyzed cities, new worlds are unveiled by the practice of the teams. The home and the school emerge as an important field of perception of problems in the MH area. PHC, operating in territories, homes and schools, uncovers problems and enhances the teams' work.

The presence of the Community Health Agent (CHA) allows the family to inform the problems they are facing.

> [...] at home, the family warns us that the person isn't well, so we contact the team to solve the problem. (GD 05)

New worlds are also unveiled by what the CHA perceives in the home.

> [...] still today, in the city, mainly because it is located in the countryside, there are MH patients that the family isolates, discriminates; it's that person who is maintained in a little room in the back of the house, who eats behind bars. We see the lack of structure of the family [...] they really need help. (GD 08)

The presence in schools through shared practices enables dentists to detect problems.

> [...] I talked to the principal because I assisted a child there and noticed that she was very withdrawn, she doesn't speak, only her lips move, and then I said: "dear, let's see what we can do for this child". (GD 01)

> [...] the little girl was behaving differently. [...] the teacher wrote a report and gave it to me, and I gave it to the psychologist who will make the appointment. (GD 02)

## Primary Care moving between distinct universes: the new dimensions that affect mental health arising from the social media

The teams' professionals also report on the expansion of the spectrum of problems experienced in PHC arising from contacts with the social media. The presence in schools enables professionals to have contact with these new themes, which end up composing the spectrum of action of PHC.

> [...] we are really concerned, we have detected many cases in the School Health Program. We had a meeting yesterday and the professionals said that the social media disrupts the patients' life, that the boys imitate other boys and have started cutting themselves. (GD 10)

> [...] the question of suicide, eating disorders, bullying. Everything comes to us. (GD 03)

## Mental health: expanding the spectrum of approach and support

The Psychosocial Care Network (known by the acronym RAPS in Brazil) has been enhanced by articulation processes involving intersectoral actions with the Child Protective Council, the Prosecution Service and the Military Police. The PHC teams participate in this new process in monthly meetings with the NASF-AB and the CAPS.

> [...] one member from each team participates in the meeting and we discuss the most critical cases, patients with mental problems, pregnant adolescents, drug users. The patients say we can't solve many of the problems, and then we are helped by the other sectors, social, education, the Child Protective Council, the Police; many times, we form partnerships. (C 01)

This process is a two-way street: both the support network and the teams bring the cases.

> [...] I get the cases and I say to the nurse: "let's put them in the network because we can't solve them by ourselves, we haven't overcome this situation". And then we go to the meeting. (G 04)

The PHC teams mention the decisive importance of the role of the CAPS in the RAPS. Moreover, they highlight the articulation with the CAPS, which share the monitoring of absent patients, hold meetings with the teams and counter-refer people with mild symptoms.

> [...] they are assisted here and there. Anyway, the psychiatrist is not at the CAPS everyday. (C 02)

> [...] I'd like to emphasize that the CAPS was one of the greatest gains. They make active searches and formed this partnership with us to check what's going on. The mild cases, which are under control and don't need the intense treatment provided by the CAPS anymore, they return to PHC. So, they come via counter-referral. (C 08)

> [...] we refer to the CAPS. Now they want more, they ask us to do it via referral by the unit, for us to follow up here. The patient stays there for some time and, when the situation is under control, we receive the counter-referral, they return the patient and we do the follow-up. If the patient destabilizes, we return them to the CAPS for a re-assessment. (C 04)

> The NASF gives support and helps a lot in cases that are not so severe. (C 06)

## Community Health Agent in action in the mental health field: daily perceptions enabling the provision of quality care

The important role of the CHA is not restricted to helping unravel new cases. Many times, they are able to build longer-lasting bonds, monitoring patients and keeping the team informed.

> [...] when the agent comes and says: "hey, I need you to do this and that, today what's his name didn't wake up well, she is agitated, she is nervous". As a matter of fact, the one who informs us about most of the things is the agent; they monitor the patients' needs. (GD 9)

> [...] in my micro-area, there was a young man who completely lost the joy of living and developed a mental problem. His mother didn't know what else she could do... I said: "What am I going to do?" He remained isolated in a room, no one had the courage to go in there. I asked God to give me strength and went there to help. Then, he listened to me. Today he is fine and I keep an eye on his medication. (GD 7)

> [...] in the home visits, you notice or perceive an alteration in behavior or speech. Or something the mother says, the son says or someone comes and we inform the nurse. We make an appointment with the doctor or refer the patient to the CAPS if necessary. (GD 4)

> [...] we also have the resistance of some patients who don't want to go to the CAPS. [...] a patient said: "I won't go", and I said: "yes, you will." They form bonds with me, with the health agent, although they are psychiatric patients. (GD 6)

## The transfer of stigmas present in the Psychosocial Care Network: "the CAPS is a place for mad people"

The daily management in the area of MH, still marked by stigmas, has an important impact on the practices of PHC teams and on the difficulty to include the family in the provided care.

> [...] is afraid to speak. He says: "the CAPS is a place for mad people". He has anxiety, he is killing himself and some people don't accept it. He even changes the tone when he speaks. It's like it's prohibited, "don't go there, because if you do, it's because you're mad", you know? (G 01)

> [...] the family ends up ruining our work. The family is the basis, and if it isn't close to the patient to help solve the problem, unfortunately nothing is done, we do our work but it's helpless, the family is needed. (G 02)

Some of the activities are targeted at dealing with stigmas.

> [...] I think what we do is beautiful, I think we allow the patients to express their feelings, the families, because many professionals and families start to see that the CAPS is not for mad people, you know? That the CAPS is a reference service. (GD 8)

> The prejudice is not of the patient; it's the luggage, it's what they carry and what they hear and what emerges. [...] they won't develop the prejudice because someone came and told them, right? Culturally, we have this thing: 'you're going to take medicines? You are mad'. The person carries it and, in fact, what happens? Mental health is a taboo to everybody. (C 06)

> [...] in the anamnesis, he immediately says: "I don't take medication". He only considers himself a normal person if he's not taking medication; it's his own prejudice. He was discharged from the CAPS, but I tell him: 'you haven't been discharged from your medication'. (G 04)

## Health promotion activities instead of medicines

The PHC teams report the effort to engage MH patients in health promotion activities that are taking place in their territories.

> [...] we try to transmit some knowledge; sometimes we succeed. We recommend drinking tea instead of taking the medicine. We say: "have you slept?" On the day you didn't sleep, you take it; on the day you could sleep, you don't; so, you take it on alternate days. [...] there are crochet and embroidery classes and we indicate them to the patients. (GD 09)

> [...] the little house where they have sewing and embroidery classes. It's health promotion; some of them ceased to take medication with the help of the crochet classes and the physical activities at the square. It's good for the body and the mind; they stop taking the medication completely. (GD 10)

> At our unit, the groups are held regularly twice a week, with hiking, Zumba, CrossFit and Muay Thai. (GD 07)

## Dedication in the daily routine of Primary Care: attentiveness to mental health medication

The professionals of PHC teams report the need to treat MH patients in a special way, recognizing their experiences and needs. They mentioned changes in the form of work organization to assist these patients, including special attention to the medication.

> [...] when patients come with some MH demand, distressed, agitated, we organize ourselves to provide assistance quickly, not to run out of medication, because we know it is one of the pillars of care. (GD 01)

> In the visits, we take the prescriptions, we provide guidance, we ask if they have questions about the medication. If they have, we call some member of the family, someone who can understand better, and we explain at what times they have to take the medicine. (GD 6)

> Our work is so demanding. We know the population is small, so we have an idea of the risk involved, we know the people who come from aggressive families, so we help and take risks. In view of the risks, we ask them to do their part, to be committed to taking the medication. (GD 07)

## Issues perceived in Primary Care regarding mental health assistance

The professionals who participated in the research mentioned problems concerning MH care. They highlighted some aspects, like the fact that they do not perform risk assessment nor make records, leaving these activities to the CAPS. Sometimes, they have a folder with the information that has been sent and they monitor the patient based on this record.

> [...] we identify a problem and refer the patient to the CAPS; there they perform the risk assessment, either taking the patient or sending them back to us [...] usually, it's not a matter to the CAPS, it's to the outpatient clinic. Then, we refer the patient to the psychologist, trying to develop actions with this 'mild' patient, but there is no formal risk assessment. (GD 05)

> We've already done searches, the CHA already know, they have a list of patients, of those who need follow-up. But today we don't have anything specific for MH patients. (GD 06)

Other problems identified by them: the fact that they do not work with drug reduction, the approach to patients with chemical dependency, and the non-formalization of detailed criteria to discharge patients from the CAPS.

[...] it's been suggested that the NASF-AB professionals should create a group to discuss and try to reduce the use of benzodiazepines, of clonazepam and the like. Many people take them and we know most don't even need it. Chemical dependency is complicated for us. (G 05)

[...] sometimes, the professionals don't have available time, logistics, transport, to do everything a mental health service should do. Today, I agree with some discharges but not with others. I don't think the patient should come ready to us from the service, but I think schizophrenic patients, patients with mental disorders who pose risks to themselves and the others, I think they should first resolve these cases and then discharge and send them back to PHC. (C 04)

## Discussion

The different worlds unveiled by managers, coordinators and PHC team workers concerning MH in small cities point to the importance of a care model in which the teams focus on the territory and reaffirm that immersion in this setting enables the integration of MH into primary care, guaranteeing rights and qualifying assistance[20,21]. The broad spectrum of problems that PHC encounters regarding mental suffering is revealed in homes and schools. The study shows that the process conceived in the sphere of the Brazilian Health Reform is deepened and becomes real in the daily practices of PHC teams, enabling the provision of comprehensive care and extending it to people with mental disorders[22,23].

The complexity of the health assistance provided in primary care is increased when it encounters the activities performed in MH. These activities encompass old practices characterized by little rooms and their bars, discovered and brought down by the CHA, the systematic monitoring of medical consultations and use of medication for patients who need it, and the current MH theme unveiled by the presence in schools and by the influence of the social media, with two groups presenting a significant growth: youths at school and young women who hurt themselves. An interview conducted with the philosopher Nikolas Rose[24] and a study carried out in the state of Santa Catarina - Brazil[25] state that mental disorders have remained consistent in the last 20 years. This means that the new challenges can lead to the structuring of MH care in PHC.

PHC and MH are updated in practice through these social actors, diving into their social realities, interacting with the complexity of their nosological classifications, and employing devices like work in a services network and matrix support. Therefore, we perceive an integrated action between PHC and the psychosocial network, enhanced by the structuring of intersectoral spaces and by an important matrix dynamics between CAPS, NASF-AB and PHC, as other studies have shown[26,27].

However, important gaps remain in the configuration of the CAPS' actions, hindering the articulation between services and affecting the provision of care by PHC teams, mainly in moments of crisis. Gaps like deficiency or even absence of matrix support, discontinuity of care on some occasions and the autonomous action of the CAPS configure a two-way street in which PHC needs to make efforts to fulfil its objectives and guarantee the provision of comprehensive and extended care[28].

Although the psychosocial network structured in the analyzed cities is relatively homogeneous, we found that the PHC teams function in distinct ways in the relationship with the other units of the psychosocial network. In some situations, PHC is structured to enhance MH care and acts to minimize the gaps that we found. The gaps in the structuring of the psychosocial network stimulates the search for new forms of action to be undertaken by PHC, as the demand for patient care effectively occurs in this level of care.

PHC organizes itself to provide care according to the needs of MH patients, prioritizing the embracement of these patients and putting a special emphasis on adherence to medication[29].

The action of the CHA is extremely important in the MH area, as they can build effective bonds, being fundamental to unveil the reality of severe MH patients. The MH practices of the PHC teams show the professionals' great involvement with the patients, which makes them important actors of the BPR[27].

Systematic reviews with national[10,27] and international[27] studies have shown that, despite the difficulties, several innovations in the MH area are present in the daily routine of PHC teams. The procedures and knowledge that emerge from PHC practices clearly show complex themes present in the making of MH policies: the approach to pathologies deriving from the social media; the complexity of intersectoral actions in common forums with the participation of the teams, involving Child Protective Councils, the Prosecution Service and the Police; the difficult discussion about MH stigmas in private spaces and some confinement practices; the systematization of discharges from the CAPS and the counter-referral to PHC.

In the analysis of the structuring of MH in PHC, conducted in practice, with its potentials and limits, it is possible to see the configuration of realities from which emerge indexical expressions that reflect the daily routine of this work[18]: "the patient wasn't discharged from the medication, he was discharged from the CAPS"; "fierce active search together with the Child Protective Council, if necessary"; "boys imitating other boys and cutting themselves". These expressions show a reality that is unveiled, involving the universes constructed in the daily MH practice in PHC.

As for the emergence of new norms or their reconfiguration based on practices, we found that the professionals' perception updates the dilemmas of the BPR[30]: the possibility that the CAPS start to be considered the new madhouse and the efforts made by the teams to prevent this; the wonderful action of the CHA, unveiling the madness stigmas in private spaces and bringing bars down, reaffirming the inclusion enabled in the sphere of the Brazilian Health Reform; the emergence of new pathologies reverberated by the social media. These issues challenge the structuring process of PHC.

This study has limitations. Because we chose ethnomethodology, it is possible that the findings represent micro-events instead of more general approaches related to the process of structuring MH actions in PHC. The option of focusing on small cities with precarious socioeconomic conditions in Vale do Jequitinhonha, state of Minas Gerais, may represent the MH reality of cities with these characteristics, not the reality experienced by the Family Health Strategy in Brazil.

## Conclusion

This study revealed important aspects of the configuration of healthcare in PHC practices, which unveil, in the daily routine, the configurations of MH actions through the professionals' presence in the territory: their presence in homes and schools sheds light on obscure fields in which the MH theme is inserted. PHC teams interacting with MH in homes and schools enables to enhance the power of MH actions, bringing bars down in the household sphere and unveiling severe cases, with significant interventions.

The configurations of intersectoral articulations put new actors on stage, with the construction of forums involving Child Protective Councils, the Prosecution Service and the Police. In addition, we found limits in the action of PHC, involving risk assessment in the MH area, structured follow-up of patients, and policies involving drug reduction. The forms of care that we found point to important flaws in the configuration of the CAPS service. In some situations, PHC is organized to overcome these gaps.

The main thing that emerges from the MH practices is the PHC teams' commitment to the patients. In the identification of MH problems in cities, new worlds are unveiled by the teams' practice and become cases to be treated.

In spite of the regressions that threaten the Brazilian Psychiatric Reform in its project of being a humanized and anti-asylum reform, it is possible to see that its principles are rooted in the practice of PHC professionals, which is an important finding of the study. Therefore, there is still hope.

## Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

## Conflict of interest

The authors have no conflict of interest to declare.

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Ações de Saúde Mental na Atenção Primária em Saúde (APS) constituem um desafio no âmbito da Reforma Psiquiátrica Brasileira (RPB). Objetivou-se a compreensão das práticas realizadas com pessoas em condições de sofrimento mental na APS em municípios de pequeno porte. O estudo qualitativo com utilização da etnometodologia envolveu gestores e profissionais da APS em municípios do Vale do Jequitinhonha. Os resultados permitiram sistematizar ações da APS: desvendar o mundo dos transtornos mentais intramuros pela visita domiciliar e a presença na escola; transitar entre universos distintos, de formatos tradicionais até os problemas de Saúde Mental advindos das redes sociais; expansão de abordagem e apoio aos pacientes de Saúde Mental e percepção pela APS da transferência de estigmas operando na rede de Saúde Mental. Conclui-se que a APS faz parte do projeto de RPB, também de forma humanizada, aprofundando-a.

**Palavras-chave:** Saúde Mental. Atenção Primária à Saúde. Estratégia Saúde da Família. Reforma Psiquiátrica Brasileira.

Acciones de Salud Mental en la Atención Primaria de la Salud (APS) constituyen un desafío en el ámbito de la Reforma Psiquiátrica Brasileña (RPB). El objetivo fue la compresión de las prácticas realizadas a las personas en condiciones de sufrimiento mental en la APS en municipios de pequeño porte. Estudio cualitativo con utilización de la etnometodología que envolvió a gestores y profesionales de la APS en municipios del Vale de Jequitinhonha. Los resultados permitieron sistematizar acciones de la APS: desvendar el mundo de los trastornos mentales intramuros, por la visita domiciliaria y de la presencia en la escuela; transitar entre universos distintos, de formatos tradicionales hasta los problemas de salud mental provenientes de las redes sociales; expansión de abordaje y apoyo a los pacientes de salud mental y percepción por parte de la APS de la transferencia de estigmas operando en la red de salud mental. Se concluyó que la APS forma parte del proyecto de RPB, también de forma humanizada y profundizándola.

**Palabras clave:** Salud mental. Atención primaria de la salud. Estrategia salud de la familia. Reforma psiquiátrica brasileña.